

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09095

★ Reg. Dist. No. 203

1. PLACE OF DEATH:

County Kent
 City or town Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 36 y.
 Hospital, institution, or street address where death occurred: Piney Creek
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Kent
 City or town Rock Hall Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Piney Creek
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Alcie Virginia Elburn

3. (b) Social Security Number

4. Sex Female 5. Color or race Wh. 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Russell Elburn
 6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb 23 1893

8. AGE: Years 52 Months 6 Days 30 It less than one day - hrs. - min.

9. Birthplace Baltimore, Md
 (Town, county, and state)

10. Usual occupation house work

11. Industry or business own home

FATHER 12. Name John G. Benton

13. Birthplace Baltimore

MOTHER 14. Maiden name Elis Josephine Crowl

15. Birthplace Kent Co, Md

16. Informant Russell Elburn

Address Rock Hall, Md

17. Buried Date thereof Sept 25, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wesley Chapel

Location near Rock Hall, Maryland

18. Funeral director J. Willis Wells

Address Pheasantown, Md

19. 9/24 Date rec'd by registrar 19 45 S. Edward Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 19 45, at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 19 45 to Sept 22 19 45 and that I last saw h. alive on about Sept 10 19 45

Immediate cause of death acute cardiac failure

Due to chron Eurocarditis

Due to Hypertension

Other conditions gallstones

(Include pregnancy within 3 months of death)

Major findings of operations -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE S. Edward Burgess M. D. other

Address Rock Hall, Md Date signed 9/22/45

RECEIVED
SEP 26 1945
BUREAU A. P.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH: Kent
 County Chestertown
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 20 Years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
Maryland.
 State Maryland. County Kent
 City or town Chestertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war No

3. (a) FULL NAME

Nancy Browne Evans.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Henry Evans
 6. (c) If alive, give age 62 years
 7. Birth date of deceased (mo., day, yr.) March 30, 1881
 8. AGE: Years 64 Months 5 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Home
 12. Name Horace B. Browne
 13. Birthplace Baltimore, Md.
 14. Maiden name Sara McGomas
 15. Birthplace Baltimore, Md.
 16. Informant Henry Evans (Husband)
 Address Chestertown Md.

17. Burial Burial Date thereof Sept. 4, 1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Woodlawn Cem.
 Location Baltimore, Maryland
 18. Funeral director J. Willis Wells
 Address Chestertown, Maryland

19. Sept 3, 1945 Clara S. Barnes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1945 19 3.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945 19 Sept. 2, 1945 19
 and that I last saw him alive on Sept. 2, 1945 19

Immediate cause of death Carcinoma Pancreas Liver Stomach.
 Due to Primary carcinoma of pancreas.
 Due to Cancer
 Other conditions None

DURATION

about
one
yr.

(Include pregnancy within 3 months of death)
 Major findings of operations as above
 Date of op. April, 1944
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of None
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Frank Jones M.D. Injured at work? None

23. SIGNATURE Frank Jones M.D. Chestertown Md. M. Sept. 3, 1945
 Address _____ Date signed _____

RECEIVED
SEP 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

09697

Reg. Dist. No. 201

1. PLACE OF DEATH:

County BentCity or town Lynch Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yearsHospital, institution, or street address where death occurred:
_____How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BentCity or town Lynch Md
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2(a) If veteran, name war _____

3. (a) FULL NAME

William Newton Haddaway

3. (b) Social Security Number

216-09-5205

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Edith May Haddaway

7. Birth date of deceased (mo., day, yr.)

July 16 1900.6. (c) If alive, give age 43 years

8. AGE:

Years 45 Months 7 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace

Bent Co Md
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Lumber

FATHER

12. Name George R Haddaway13. Birthplace Chesapeake Md14. Maiden name Sarah Henney15. Birthplace Chesapeake Md16. Informant Wm Edith HaddawayAddress Lynch Md.17. Buried Date thereof Sept 20 1945
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory St PaulsLocation Still Pond Md18. Funeral director Still Pond MdAddress Still Pond Md19. Sept 20 19 45 Registrar J. M. Black

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1945 at 6:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1945 to Sept 18 1945 and that I am a duly licensed physician.Immediate cause of death as above DURATION 18Due to Coronary ThrombosisDue to ArteriosclerosisOther conditions None

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury None Injured at work? None23. SIGNATURE Dr. M. D. H. H. H.Address Chesapeake Md Date signed Sept 18 1945

RECEIVED
SEP 24 1945
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1919

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

09098

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

County KentCity or town Lynch
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 26 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Lynch
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ruth A Oliver

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Thomas J. Oliver6.(c) If alive, give age 89 years7. Birth date of deceased (mo., day, yr.) Aug 14 18638. AGE: Years 82 Months 1 Days 3 It less than one day _____ hrs. _____ min.9. Birthplace Harford County Md.
(Town, county, and state)10. Usual occupation housewife11. Industry or business noneFATHER 12. Name George Miller13. Birthplace Harford Co. Md.MOTHER 14. Maiden name Marj E. Anderson15. Birthplace Harford Co. Md.16. Informant Mr. Herbert OliverAddress Lynch, Maryland17. Burial Date thereof Sept 20, 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Marys.Location Emmorton Md.18. Funeral director Marvin V. WilliamsAddress Chesapeake Md.19. Sept 18 19 45 J. M. Clark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 19 45 at 12:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 17 19 45 to 19and that I last saw him/her alive on Sept 17th 19 45Immediate cause of death Cranial Hemorrhage

DURATION

1 hourDue to ThrombosisDue to Arterial Sclerosisand Arthritis5 yrs.3 yrs.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. P. Oliver M. D. or otherAddress Slieve Ford Date signed 9/17/45

RECEIVED

SEP 24 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 630

CERTIFICATE OF DEATH

Reg. Dist. No. 204

1. PLACE OF DEATH:

County KentCity or town Fairlee - Rural town
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Fairlee
(If outside city or town limits, write RURAL and give nearest town)Street No. Chestertown RR. Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Blanche Smythe Skinner

3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or C. Romie Skinner6. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) 1-31-18798. AGE: Years 68 Months 7 Days 29 If less than one day
.....hrs.min.9. Birthplace Kent County
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Richard C Smythe13. Birthplace Kent County14. Maiden name Williamina Appelton15. Birthplace Delaware16. Informant C. Romie Skinner HusbandAddress Fairlee, Chestertown Rd.17. Burial Date thereof 10-2-1945
(Burial, cremation, or elsewhere) (month) (day) (year)Cemetery or crematory ChesterLocation Chestertown, Md.18. Funeral director J. H. H. H. H.Address Chestertown Rd.19. Sept 30 1945 Frank W Smith
(Date rec'd by registrar) (year) (month) (day) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1945 at 12:50 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1944 to Sept. 18 1945
and that I last saw him alive on Sept 29 1945Immediate cause of death Cerebral Apoplexy

DURATION

Due to Chronic Arteriosclerosis 5 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank W Smith M.D.
M. D. or otherAddress Chestertown RR Date signed 9/30/45

RECEIVED
BUREAU
OCT 4 1961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(52-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 09100 201

1. PLACE OF DEATH:

County Kent
 City or town Mountain View Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? one year
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clara Starling

3. (b) Social Security Number

4. Sex Female 5. Color or race C 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Charley Starling
 7. Birth date of deceased (mo., day, yr.) Sept 12 1884
 6. (c) If alive, give age _____ years
 8. AGE: Years 61 Months _____ Days 18 If less than one day _____ hrs. _____ min.

8. Birthplace Morgans Kent Md
(town, county, and state)10. Usual occupation House work

11. Industry or business

12. Name Richard Robinson
 13. Birthplace South Carolina
 14. Maiden name Thompkins
 15. Birthplace Morgans Md

16. Informant Mattie Harris
 Address Chestertown Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof Sept 16/45
 (month) (day) (year)

Cemetery or crematory Morgans churchyardLocation Morgans Chestertown Md18. Funeral director B & B FellowsAddress Still Pond Md

19. Sept 15 1945 Registrar Malark
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Kent
 City or town Mountain View Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1945 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1945 to Sept 12 1945
 and that I last saw her alive on 9-11 1945

Immediate cause of death uremia DURATION _____ca of heartHypertensionchronic - myocarditis

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations ca of heart

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Amelia Buggard M. D. or other _____Address Back Hall Md Date signed 9/15/45

RECEIVED
SEP 18 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 200

CERTIFICATE OF DEATH

Reg. Dist. No. 09101 202

1. PLACE OF DEATH:

County... Kent
 City or town... Chestnut
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 45 da.
 Hospital, institution, or street address where death occurred:
 210 Cross St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Cecil
 City or town... Perry Point Veteran Hospital
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Perryville, Maryland
 (If rural, give LOCATION)
 2(a) if veteran, name war... World War I

3. (a) FULL NAME

William Henry Thomas

3. (b) Social Security Number

217-16-9748

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed or divorced

Married

6. (b) Name of husband or wife

Ada Eland

7. Birth date of deceased (mo., day, yr.)

1896

8. (c) If alive, give age... years

8. AGE:

49

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Near Church Hill Green and
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

William John Wesley Thomas

13. Birthplace

Queen Anne Co., Md.

MOTHER

14. Maiden name

Martha Thomas Tiller

15. Birthplace

Pondtown, Queen Anne Co., Md.

16. Informant

Florence Robinson

Address

210 Cross St.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof... Sept. 11 1945
(month) (day) (year)

Cemetery or crematory

Pondtown - Bethel

Location

Pondtown - Chestnut P.O. = 2nd

18. Funeral director

Wm. V. Williams

Address

Chestnut, Maryland

19. (Date rec'd by registrar)

Sept. 11 1945

19. (Date rec'd by registrar)

Class S. Barnes

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

September 8, 1945, at 10:30 A.M.

and that death occurred on the date above stated, that the deceased was
 + signed Certificate of death as required by law
 and that the cause of death was... Syphilis

Immediate cause of death

Q + S Syphilis

Due to

Jaundice

Due to

Postural Paralysis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address... Pondtown, Md. Date signed... Sept. 10/45

RECEIVED

SEP 13 1945

RECEIVED
SEP 13 1945
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH:

County KentCity or town Rock Hall
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Rock Hall
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Caroline A. Urie

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife George Urie

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept 30 18638. AGE: Years 81 Months 11 Days 17 If less than one day _____ hrs. _____ min.9. Birthplace Rock Hall, Md.
(Town, county, and state)10. Usual occupation House work11. Industry or business own house12. Name George & Satter Urie13. Birthplace Rock Hall14. Maiden name Ella Eisenbrier15. Birthplace Rock Hall16. Informant Edwin UrieAddress Rock Hall, Md.17. Burial Date thereof Sept. 20 1945
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Wesley ChapelLocation Rock Hall Md.18. Funeral director Edgar L LaneAddress Clunch Hill Md.19. 9/19/45 19 _____(Date rec'd by registrar) Registrar S. Elwood Burgess

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 19 45 at 508 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 45 to Sept 30 19 45and that I last saw her alive on 9-18 19 45

Immediate cause of death _____ DURATION _____

Ca of bladderHemorrhageDue to chron. Eule - myocarditisdecompensation

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Arthur L Burgess M. D. otherAddress Rock Hall, Md. Date signed 9/18/45

RECEIVED
SEP 20 1945
BUREAU V.S.